TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health Associates

Respondent Name
Travelers Casualty Ins Co of America

MFDR Tracking Number
M4-17-3668-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
August 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Review of records indicate this was [claimant] first psychological evaluation; therefore, preauthorization was not required."

Amount in Dispute: $900.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends CPT code 90791 requires preauthorization based on the services performed by the Provider in the diagnostic evaluation. On page 7 of the Provider's report of the evaluation, the Provider documents that psychological testing was conducted. The testing included the McGill Pain Questionnaire, the Beck Depression Inventory, and the Beck Anxiety Inventory, among other questionnaires. As "all psychological testing" requires preauthorization, and the purpose of the Provider's psychiatric diagnostic evaluation was to test the Claimant's psychological condition in order to recommend an appropriate treatment protocol, the evaluation required preauthorization."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2016	90791	$900.00	$206.43

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

3. 28 Texas Administrative Code §134.600 sets out requirements of prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 38 – Services not provided or authorized by designated (network/primary care) providers
   - P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payment policies
   - W3 – Additional payment made on appeal/reconsideration
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - TR12 – Pre-authorization was not obtained prior to the service/procedure being rendered

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for Code 90791 – "Psychiatric diagnostic evaluation" performed on December 18, 2016 in the amount of $900.00.

   The insurance carrier denied disputed services with claim adjustment reason code TR12 – "Pre-authorization was not obtained prior to the service/procedure being rendered."

   28 Texas Administrative Code §134.600 (p) (7) states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   >
   > (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;

   The carrier states "…the purpose of the Provider's psychiatric diagnostic evaluation was to test the Claimant's psychological condition in order to recommend an appropriate treatment protocol, the evaluation required preauthorization." The requestor states, "…this was (injured worker's) first psychological evaluation; therefore, preauthorization was not required.

   Review of the medical bill finds only Code 90791 – "Psychiatric diagnostic evaluation" was submitted and is in dispute. Rule 134.600 (p) (7) requires prior authorization on testing. As only the evaluation was billed, the carrier's position is not supported. The service in dispute will be reviewed per applicable fee guideline discussed below.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

Date of Service	Submitted Code	Allowed Amount	Units	(DWC Conversion Factor / Medicare Conversion Factor) x Allowable - MAR
December 18, 2016	90791	$130.08	3	56.82/35.8043 x $130.08 = $206.43

   The medical bill was submitted with three units. Insufficient documentation was found to support more than one evaluation was done on this date of service. Therefore, only one unit will be reimbursed per the provisions of Rule 134.203 (b).

3. The total allowed amount for the service in dispute is $206.43. The carrier previously paid $0.00. The remaining balance of $206.43 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $206.43.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable) the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $206.43, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	September 19, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.